State of Wisconsin Medicaid HIT Plan
Version 3.0

Appendix A

Patient Volume Methodology

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One of the primary eligibility requirements of the Medicaid EHR Incentive Program is meeting Medicaid (Title XIX) patient volume thresholds. The patient volume threshold is specific to the Eligible Professional (EP) or Hospital over a representative, continuous 90 day period. Due to the integrated delivery of Medicaid and BadgerCare+ under Wisconsin's ForwardHealth Program, the Wisconsin Department of Health Services anticipates difficulty for EPs and Hospitals determining their Medicaid (Title XIX) encounters without intervention and assistance from the Wisconsin Medicaid Agency. To mitigate this problem, the Wisconsin Medicaid Agency has developed the following methodologies for EPs and Hospitals to obtain their Medicaid patient volume.

1. Eligible Professional Patient Volume

In order to participate in the Wisconsin Medicaid EHR Incentive Program, an EP must be classified on the Wisconsin Medicaid Management Information System (MMIS) as one of the eligible provider type and specialty combinations detailed in Section 3: Program Administration and Oversight.

Provider Type	Title XIX Threshold	Needy Individuals
Physicians	30%	Or the Medicaid Eligible Professional practices predominantly in a FQHC or RHC with a minimum 30% Needy Individuals Patient Volume
Pediatricians	20%	
Dentists	30%	
Certified Nurse Midwives	30%	
Nurse Practitioners	30%	
Physician Assistants (PAs) practicing in a FQHC RHC that is so led by a PA	30%	

Figure A.1: Patient Volume Threshold

In addition to other program requirements, EPs must meet Medicaid (Title XIX and Medicaid funded Title XXI) patient volume thresholds. Patient volume thresholds shall be determined by examining encounter data over the course of a 90 day period for each EP in the calendar year preceding the payment year or a 90 day period in the 12 months directly preceding the attestation date. EPs applying during the grace period must ensure that they are attesting to a 90 day period that falls within the acceptable attestation date range for the program year for which they are applying.

Generally, EPs must meet a minimum thirty (30) percent Medicaid (Title XIX) patient volume. However there are some exceptions. Pediatricians can be found eligible with a minimum twenty (20) percent Medicaid (Title XIX) patient volume. Pediatricians with a minimum twenty (20) percent patient volume, but less than thirty (30) percent patient volume will receive a reduced incentive payment, equal to 2/3 of the full EP incentive payment amount.

EPs that practice predominantly in a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) must have a minimum thirty (30) percent patient volume attributable to Needy Individuals. For more information on Needy Individual Patient Volume requirements, please refer to Section 1.1.4 of this document.

1.1. Wisconsin's Eligible Professional Medicaid Patient Volume Methodology

Determining patient volume is a critical component in determining if Wisconsin's providers will be eligible for the Wisconsin Medicaid EHR Incentive Program. The Wisconsin Medicaid Agency has adopted the patient volume calculation as defined in the Medicare and Medicaid Programs; Electronic Health Record Incentive Program Final Rule as the core of Wisconsin's methodology; calculating Medicaid

$$\left[\frac{\text{Total Medicaid Title XIX Patient Encounters in any 90-day period in the preceding calendar year or in the 12 months preceding the attestation date}}{\text{Total Patient Encounters in that same 90-day period}}\right] * 100$$

Figure A.2: EP Patient Volume Calculation

thresholds using, as the numerator, the individual EP's total Medicaid (Title XIX) and Medicaid Funded CHIP (Title XXI) patient encounters in any representative, continuous 90-day period in the preceding calendar year or in the 12 months preceding the attestation date over the denominator of all patient encounters for the same EP during the same 90-day period.

Due to the integrated delivery of Medicaid and BadgerCare+ under Wisconsin's ForwardHealth Program, the Wisconsin Medicaid Agency anticipates difficulty for EPs to determine their Medicaid (Title XIX) and Medicaid Funded CHIP (Title XXI) encounters without intervention and assistance from the Wisconsin Medicaid Agency. To mitigate this problem, the Wisconsin Medicaid Agency helps program applicants determine their eligible encounters by providing a standard methodology for deducting non-Medicaid Funded CHIP encounters.

1.1.1. Understanding the Eligible Professional Medicaid Patient Volume Numerator

For the Medicaid patient volume numerator, a Medicaid (Title XIX) encounter is defined as services rendered on any one day to a Medicaid enrolled individual. This definition includes encounters where the Medicaid paid amount is equal to zero and also encounters where the provider saw individuals under Title XXI-funded Medicaid expansions (but not separate CHIPs). For use in determining patient volume, encounters may be aggregated at either at the individual EP or group practice level. The below explanations illustrate the Medicaid (Title XIX) definition of encounter at the individual and group practice level.

1. *Individual Eligible Professionals:* EPs attesting to the Individual Patient Volume are required to submit their individual patient volume data. The information used by the EP to calculate Patient Volume should follow the CMS definition provided above. Please note that multiple providers may submit an encounter for the same individual if the encounters take place within the providers' scope of practice. However, multiple visits or services rendered to the same patient by the same provider on the same day may only be counted as one encounter.
2. *Group Practice:* Group practices are required to use the entire practice's patient volume and not limit it in any way during the application process. Encounters for a group practice will represent all Medicaid paid claims for which the group practice is identified as the billing provider by the National Provider Identifier (NPI) on the claim. Denied claims will not be included in an EP Medicaid patient volume numerator. Only those rendering providers identified on paid claims submitted during the representative, continuous 90 day period will be permitted to use group practice patient volume. If a group practice chooses this methodology for the patient volume calculation, <u>all</u> EPs in the clinic or practice must use the practice/clinic Medicaid patient volume when applying.

As Title XXI encounters cannot be included in the determination of Medicaid encounter volumes unless it is Medicaid funded, this presents a barrier to EPs. EPs cannot distinguish Medicaid (Title XIX) and Medicaid Funded CHIP (Title XXI) from Non-Medicaid Funded CHIP (Title XXI) encounters. To reduce this barrier, the Wisconsin Medicaid Agency annually calculates a standard deduction percentage of CHIP beneficiaries to be subtracted from the total Medicaid and

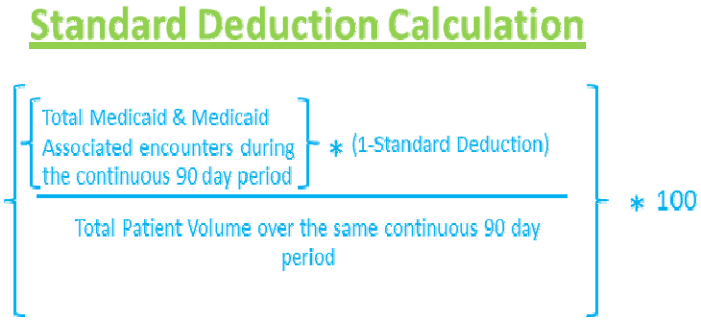

Figure A.3: Standard Deduction Calculation

BadgerCare+ beneficiary encounters. EPs must use this as a resource for removing their CHIP volume when attesting to their Medicaid patient volume. The Wisconsin Medicaid Agency will communicate the Standard Deduction annually prior to the start of the Program Year.

Total encounters attributable to Medicaid should be reduced by this amount in order to remove Non-Medicaid Funded CHIP encounters and isolate Title XIX and Medicaid Funded Title XXI encounters as the patient volume numerator.

For example, an EP practicing in the State of Wisconsin may calculate that he/she has 35 Medicaid and BadgerCare+ encounters but cannot distinguish Medicaid (Title XIX) and Medicaid funded CHIP from Non-Medicaid funded CHIP (Title XXI). Since there is not a way for EPs to differentiate between Medicaid and CHIP patients, the EP will reduce his or her total count of Medicaid encounters by the Standard Deduction to eliminate the CHIP (Title XXI) encounters. The 35 encounters are multiplied by (1-Standard Deduction) and then divided by the total encounters during the same period. In the following examples, the Standard deduction is assumed to be 8.08% (1 - .0808 = 0.9192)

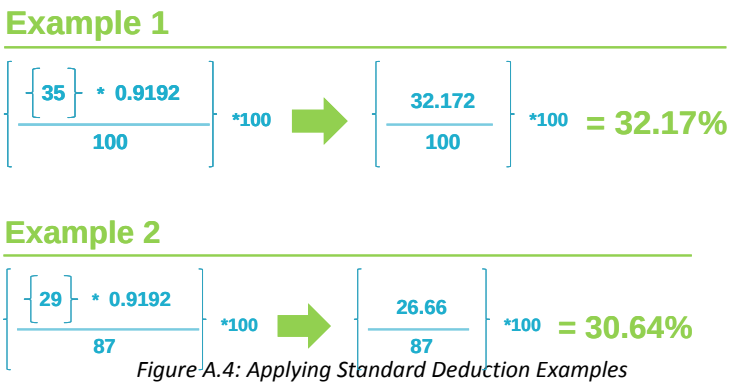

Figure A.4: Applying Standard Deduction Examples

1.1.2. Calculating Patient Volume Denominator

In order to accurately reflect all services rendered, the Wisconsin Medicaid Agency will require all EPs to provide and attest to the accuracy of their submitted patient volume. A common definition of encounters must be applied to both the numerator and denominator to ensure the patient volume percentage is accurate. To calculate the patient volume for the Medicaid EHR Incentive Program, an individual EP should consider the following:

1. *Individual Eligible Professionals.* When utilizing individual patient volume, an EP must include all encounters in their denominator regardless of payer. An encounter is defined as services rendered on any one day to an individual for whom the professional was the rendering provider.
2. *Group Practice.* When utilizing group practice patient volume, an EP must include all encounters in their denominator regardless of payer for the entire group practice. This includes the services rendered for all providers within the group practice, regardless of provider type or eligibility status. An encounter is defined as services rendered on any one day to an individual for whom the professional was the rendering provider.

1.1.3. Group Practice

Patient volume thresholds may be met at the individual or group practice level. For the purposes of determining patient volume, a group practice is defined by the billing NPI of the group practice. This is the billing provider NPI used on Medicaid claims submitted to the Department of Health Services. Group

practices will be permitted to calculate patient volume at the group practice/clinic level, but only in accordance with the following limitations:

1. The group practice's patient volume is appropriate as a patient volume methodology calculation for the EP. DHS will deem a practice's patient volume as appropriate for an EP only if Medicaid patients were served by the EP during the 90 day period.
2. There is an auditable data source to support a clinic's or group practice's patient volume determination.
3. All EPs in the group practice or clinic must use the same methodology for the Program Year.
4. The group practice uses the entire practice or clinic's patient volume and does not limit patient volume in any way.
5. If an EP works inside and outside of the clinic or practice, then the patient volume calculation includes only those encounters associated with the group practice, and not the EP's outside encounters.

When electing to use group practice patient volume, the entire practice's patient volume must be included. This includes the services rendered by all providers within the group practice, regardless of provider type or eligibility status.

The following illustrates an example of aggregating a group practice's patient volume.

Class	Description	Encounters (Medicaid/ Total)
EP	Physician: individually had 40% Medicaid and BadgerCare+ encounters	80/200
EP	Nurse practitioner: individually had 50% Medicaid and BadgerCare+ encounters	50/100
-	Registered nurse, but not an EP: individually had 75% Medicaid and BadgerCare+ encounters	150/200
-	Practitioner at the clinic, but not an EP (pharmacist): individually had 80% Medicaid and BadgerCare+ encounters	80/100
EP	Physician): individually had 10% Medicaid and BadgerCare+ encounters	30/300
EP	Dentist: individually had 5% Medicaid and BadgerCare+ encounters	5/100
EP	Dentist: individually had 30% Medicaid and BadgerCare+ encounters	60/200

Figure A.5: Group Patient Volume Example

In this scenario, there are 1200 encounters in the selected 90-day period. There are 455 encounters attributable to Medicaid and BadgerCare+. Assuming that the Standard Deduction is once again 8.08%, the 455 encounters need to be multiplied 0.9192 to eliminate Non-Medicaid funded CHIP encounters leaves 418.236 Medicaid encounters. The new total which accounts for the standard deduction yields a group practice's Medicaid patient volume as 34.854%. This means that 5 of the 7 professionals would meet the Medicaid patient volume criteria under the rules for the Medicaid EHR Incentive Program. Two of the professionals are not eligible for the program but their clinical encounters at the group practice should be included.

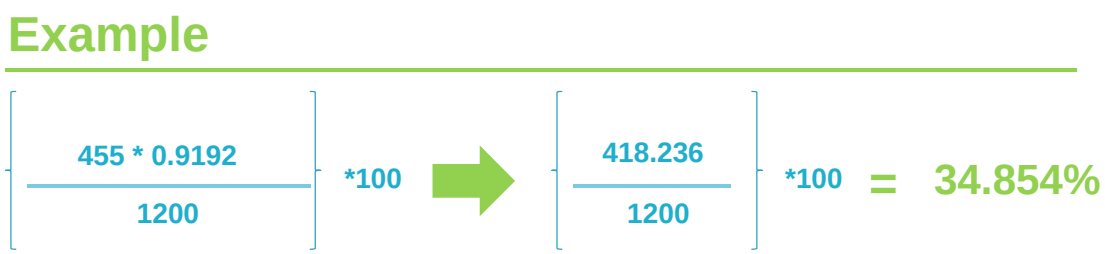

Figure A.6: Group Practice Patient Volume Example

1.1.4. Federally Qualified & Rural Health Centers Eligible Professionals

Medicaid EPs practicing predominantly in a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) are eligible to apply for the Medicaid EHR Incentive Program using "Needy Individual" patient volume calculations. In order to meet the definition of practicing predominantly, the clinical location for over 50 percent of an EP's total patient encounters over a period of 6 months in the prior calendar year or in the 12 months preceding the EP's attestation must occur at a FQHC or RHC.

EPs practicing predominately in an FQHC or RHC must have a minimum of thirty (30) percent patient volume attributable to "needy individuals" encounters over any representative, continuous 90-day period in the preceding calendar year or in the 12 months preceding the attestation date. For purposes of calculating EP patient volumes, an encounter will be defined as services rendered on any one day to an individual. Multiple visits or services rendered to the same patient by the same provider on the same day may only be counted as one encounter.

The thirty (30) percent patient volume threshold may be met at the individual or practice level. For more information on the group patient volume specifications, please refer to section 1.1.3 of this document.

1.1.4.1. Understanding the Needy Individual Patient Volume Numerator

When calculating the Needy Individual patient volume numerator, only the following types of encounters may be included:

1. Services rendered on any one day to an individual where the patient was a Medicaid enrolled individual.
2. Services rendered on any one day to an individual where CHIP under Title XXI paid for part or all of the service.
3. Services rendered on any one day to an individual furnished by the provider as uncompensated care.
4. Services rendered on any one day to an individual furnished at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

To calculate Needy Individual patient volume for individual EPs, only those encounters where the EP personally rendered services should be included in the numerator. However, if patient volume is to be calculated on a group practice level, the numerator may include all Needy Individual encounters (as defined above) attributable to the group practice for each professional billing under the practice.

1.1.4.2. Calculating Needy Individual Patient Volume Denominator

In order to accurately reflect all services rendered, the Wisconsin Medicaid Agency will require all EPs to provide and attest to the accuracy of the patient volume denominator. To calculate patient volume for the Medicaid EHR Incentive Program, an individual EP should consider the following:

1. *Individual Eligible Professionals.* When utilizing individual patient volume, an EP must only include the total services rendered on any one day to an individual for which the professional was the rendering provider.
2. *Group Practice.* When utilizing group practice patient volume, an EP must only include the total services rendered on any one day to an individual for the entire group practice. This includes the services rendered for all providers within the group practice, regardless of type or eligibility status.

2. Hospital - Patient Volume

One of the primary eligibility requirements of the Medicaid EHR Incentive Program is meeting Medicaid (Title XIX) patient volume thresholds. The patient volume threshold is specific to the Hospital (at the CCN Level) over a representative, continuous 90 day period in the preceding Federal Fiscal Year for the Hospital.

Provider Type	Title XIX Threshold
Acute Care Hospitals	10%
Children's Hospital's	No Requirement

Figure A.7: Hospital Patient Volume Threshold

In order to participate in the Wisconsin Medicaid EHR Incentive Program, a hospital must be classified as an Acute Care Hospital, defined as a hospital within the CCN range of 0001- 0879 or 1300 – 1399, or a Children's Hospital, defined as a hospital within the CCN range of 3300 – 3399. Hospitals which predominately treat individuals under the age of 21 as a freestanding hospital or hospital within a hospital but do not have CCNs are also eligible for the Medicaid EHR Incentive Program so long as they meet existing criteria. Since there is no Medicaid patient volume threshold requirement for Children's Hospitals, the section that follows is directed towards Acute Care Hospitals only. Children's Hospitals will not be required to record Medicaid patient volume as part of the application process for the Wisconsin Medicaid EHR Incentive Program.

2.1. Wisconsin's Hospital Medicaid Patient Volume Methodology

Determining patient volume is a critical component in determining if Wisconsin Hospitals will be eligible for the Wisconsin Medicaid EHR Incentive Program. The Wisconsin Medicaid Agency has adopted the patient volume calculation as stated in the Final Rule as the core of Wisconsin's methodology; calculating Medicaid thresholds (represented above) using as the numerator the individual Hospital's total Medicaid (Title XIX) and Medicaid funded CHIP patient encounters in any representative, continuous 90-day period in the preceding Federal Fiscal Year over the denominator of all patient encounters for the same Hospital during the same 90-day period.

$$\left[\frac{\text{Total Medicaid Title XIX Patient Encounters in any 90-day period in the preceding calendar year or in the 12 months preceding the attestation date}}{\text{Total Patient Encounters in that same 90-day period}}\right] * 100$$

Figure A.8: Hospital Patient Volume Calculation

For purposes of calculating the patient volume for Acute Care Hospitals, an encounter will be defined as:

1. Services rendered to an individual per inpatient discharge
2. Services rendered to an individual in an emergency department on any one day

Due to the integrated delivery of benefit programs under Wisconsin ForwardHealth, the Wisconsin Medicaid Agency anticipates difficulty for Hospitals to determine their Medicaid (Title XIX) encounters without intervention and assistance from the Wisconsin Medicaid Agency. To mitigate this problem, the Wisconsin Medicaid Agency will help program applicants determine their Medicaid (Title XIX) encounters by aggregating Managed Care and Fee-For-Service claims stored in the Data Warehouse / Decision Support System (DW/DSS). For inclusion in the Medicaid (Title XIX) patient encounters numerator, encounters count as services provided to an individual enrolled in Medicaid or Medicaid funded CHIP program. Encounters which have been denied, for any reason, will not be included in a Hospital Medicaid patient volume numerator.

To clearly delineate eligible encounters from ineligible ones, the Wisconsin Medicaid Agency will utilize internal fund codes assigned to all Managed Care and Fee-For-Service encounters, the same method used to report quarterly Medicaid expenditures through the CMS-64. A fund code is a predetermined combination of attributes, including its program component, which identifies any financial transaction in the State of Wisconsin's Medicaid Management Information System, ForwardHealth interChange.

A component of patient volume is the period in which it will be determined. For Acute Care Hospitals, the Wisconsin Medicaid Agency has defined the 90-day period as one of the Federal Fiscal Year quarters in the Federal Fiscal Year preceding the Program Year. If a hospital fails to meet the patient volume requirement using the data from one of the quarters, the hospital may submit a request to the Wisconsin Medicaid Agency to reassess patient volume using the Hospital's dictated 90-day period in the Federal Fiscal Year preceding the Program Year.

2.1.1. Understanding the Hospital Medicaid Patient Volume Numerator

The integrated delivery of benefit programs under Wisconsin ForwardHealth, presents a barrier to Acute Care Hospitals in identifying Medicaid encounters. Hospitals are unable to differentiate between Medicaid encounters and the Non-Medicaid Funded CHIP encounters. To help alleviate this barrier, the Wisconsin Medicaid Agency will calculate the hospital Medicaid patient volume in-state numerator based on the encounter data available through the State's Data Warehouse/Decision Support System (DW/DSS).

For the patient volume numerator, a Medicaid encounter is defined as:

1. Services rendered to an individual per inpatient discharges where the individual is enrolled in a Medicaid or a Medicaid demonstration project.
2. Services rendered to an individual in an emergency department on any one day where the individual is enrolled in a Medicaid or a Medicaid demonstration project.

The Wisconsin Medicaid Agency will utilize the following conditions when aggregating institutional claims into a hospital encounter.

Condition	Description
Hospital	Only encounters attributed to the hospital through the billing provider NPI on the submitted encounter will be included in the Medicaid Patient Volume Numerator. In order to limit to those attributed to the hospital, provider type codes and internal system assigned keys will be used.
Claim Types	The Medicaid Patient Volume Numerator will only include Inpatient, Inpatient Cross-Over, Out-Patient, and Out-Patient Cross-Over encounters attributed to the hospital.
Claim Status	The Medicaid Patient Volume Numerator will only include Medicaid enrolled patient encounters.
Payer	To clearly differentiate Medicaid encounters from Non-Medicaid Funded CHIP encounters, the Wisconsin Medicaid Agency will use internal fund codes assigned to all Managed Care and Fee-For-Service encounters. A fund code is a predetermined combination of attributes, which identifies any financial transaction in the State of Wisconsin's Medicaid Management Information System, ForwardHealth interChange. Only Medicaid assigned fund codes will be included in the Medicaid Patient Volume Numerator. This approach ensures that Medicaid Funded CHIP encounters are not excluded from the calculation.
Active Indicator	To prevent duplicate counting of re-submitted encounters, only encounters with the active indicator set to Yes will be included in the Medicaid Patient Volume Numerator.
Patient Status	The Medicaid Patient Volume Numerator will only include Medicaid Inpatient and Inpatient Cross-Over encounters with a patient status indicating a discharge, left against medical advice, or deceased. Patient transfers are not considered discharges.
Inpatient Discharges	Inpatient Discharges will only include one encounter for each inpatient discharge regardless of the number of services rendered during the inpatient stay.

Condition	Description
Emergency Department	The Medicaid Patient Volume Numerator will only include encounters taking place in an emergency department, identified through revenue codes '0450', '0451', '0452', and '0459' Using these identified encounters, the encounters are then consolidated by grouping all encounters from each day, so that only one encounter per Medicaid member per day is counted, regardless of the number of services rendered during the Emergency Department visit. Note: Urgent Care encounters, identified through Revenue Code 0456, are not included in the Medicaid Patient Volume Numerator. .

Figure A.9: Hospital Encounter Conditions for Patient Volume Calculation

The Final Rule identifies a hospital by using its Medicare provider number (referred to as the CMS Certification Number, or CCN, in the rule). Multiple hospitals campuses with multiple National Provider IDs (NPI) but sharing one CCN will receive only one incentive payment. These hospitals will consolidate patient volume numerators and denominators for each campus to determine patient volume.

2.1.2. Calculating Patient Volume Denominator

In order to provide health care providers, insurers, consumers, governmental agencies and others information concerning health care providers, all Wisconsin hospitals are required, pursuant to Chapter 153 of the Wisconsin Statutes, to provide quarterly discharge data to an "entity" contracted by the Wisconsin Department of Health Services. That entity is the Wisconsin Hospital Association (WHA) Information Center LLC.

The inpatient, emergency department visit, outpatient surgery, and observation care data collected by the WHA Information Center is subject to certain data verification, review and comment procedures specified by Chapter 153 of the Wisconsin Statutes, by 2001 HFS 120 of the Wisconsin Administrative Code, and by contract with the State of Wisconsin. Pursuant to 2001 HFS 120.11(3)c., the hospital's CEO or designee must sign an affirmation that the data submitted by the hospital to WHA Information Center is accurate to the best of his or her knowledge. Facilities that fail to comply with data submission requirements may be subject to forfeitures. Finally, pursuant to Chapter 153 of the Wisconsin Statutes, the WHA Information Center is required to provide the collected data to the Wisconsin Department of Health Services (DHS).

To calculate Wisconsin Hospital patient volume for the Medicaid EHR Incentive Program, WHA Information Center will provide the Wisconsin Medicaid Agency denominator data broken out into six categories, each of which is defined and explained below.

1. *Total inpatient discharges (INP).* This data represents all inpatient discharges of Wisconsin residents from an inpatient hospital unit in the specified time period. The total was calculated by summing for each hospital the number of reported inpatient DISCHARGE DATES in which the patient had a PATIENT ZIP CODE in Wisconsin and did not have a MSDRG that corresponded to a "normal newborn" (MSDRG 795).
2. *Emergency department (ER).* This data represents all discharges of Wisconsin residents from a hospital emergency department in the specified time period, except when an individual is discharged from the emergency room to an inpatient unit, an observation unit, or to outpatient surgery. The total was calculated by summing for each hospital the number of reported emergency DISCHARGE DATES in which the patient had a PATIENT ZIP CODE in Wisconsin, except that only a single DISCHARGE DATE was counted if a patient had multiple discharges from the same hospital's emergency department on the same day. It is important to note that discharges from a hospital emergency department to an inpatient unit, an observation unit, or to outpatient surgery are not

reported to WHA Information Center as an emergency room discharge. Rather, such discharges are reported as an ER-INP, ER-OBS, or ER-OPS patient; these totals are explained below.

3. *Inpatient that came from the emergency department (ER-INP*). This data represents all discharges of Wisconsin residents from an inpatient hospital unit in the specified time period in which the discharged patient came to the inpatient unit from the hospital's emergency department. The total was calculated by summing for each hospital the number of reported INPATIENT DISCHARGE DATES in which the patient had a PATIENT ZIP CODE in Wisconsin and had a TYPE OF BILL CODE of 11x or 12x that also corresponds to a revenue code of 0450, 0451, 0452, or 0459.
4. *Observation unit patient that came from the emergency department (ER-OBS).* This data represents all discharges of Wisconsin residents from a hospital observation unit in the specified period in which the discharged patient came to the observation unit from the hospital's emergency department. The total was calculated by summing for each hospital the number of reported OBSERVATION UNIT STATEMENT PERIOD END DATES in which the patient had a PATIENT ZIP CODE in Wisconsin and had REVENUE CODES of 0760 or 0762 (observation) AND 0450, 0451, 0452 or 0459 (emergency department).
5. *Outpatient surgery patient that came from the emergency department (ER-OPS).* This data represents all discharges of Wisconsin residents from a hospital outpatient surgery department in which the discharged patient came to the outpatient surgery department from the hospital's emergency department. The total was calculated by summing for each hospital the number of reported OUTPATIENT SURGERY PROCEDURE DATES in which the patient had a PATIENT ZIP CODE in Wisconsin and had REVENUE CODES of 036x, 0481, 049x, or 0750 (outpatient surgery) AND 0450, 0451, 0452 or 0459 (emergency department).
6. *Total.* This is the sum of items 1) through 5) above.

In order to streamline the application process, the Wisconsin Medicaid Agency will utilize the WHA information Center to provide total inpatient and Emergency Department denominator data for all Wisconsin Hospitals.

2.1.3. Hospital Patient Volume Process

To simplify the identification of Medicaid encounters and ease the application process, the Wisconsin Medicaid Agency will pre-qualify Acute Care Hospitals for the patient volume eligibility requirement. To expedite the patient volume pre-qualification process, the Wisconsin Medicaid Agency has set a policy to use Federal Fiscal Year to be used in calculating patient volume for Wisconsin Hospitals. The Wisconsin Medicaid Agency calculates in-state Medicaid encounter data available through the State's DW/DSS to establish each hospitals pre-qualification numerator. The WHA Information Center provides the total encounter denominator data to the Wisconsin Medicaid Agency. Initially, Medicaid patient volume will be calculated for all Acute Care Hospitals for the first quarter of the Federal Fiscal Year. The Wisconsin Medicaid Agency will communicate qualification under patient volume requirements and the FFY quarter the hospital qualified through e-mail.

Only those hospitals that do not meet the patient volume threshold in the first quarter will continue to have their patient volume analyzed for additional quarters of the year. The Wisconsin Medicaid Agency maintains a list of the pre-qualified Acute Care Hospitals that it has determined meet the patient volume requirement for each Program Year and uses this list to verify each hospital's pre-qualification during the application process. If a hospital fails to pre-qualify for the patient volume requirement, the hospital may submit a request to the Wisconsin Medicaid Agency to reassess their patient volume. These requests are resolved on a case by case basis.